Zahnarztpraxis
Am Weiherschloss

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Zahnarztpraxis am Weiherschloss AG I Therwilerstrasse 2 CH-4103 Bottmingen I Tel 061 426 97 97 I www.zahnarzt-weiherschloss.ch

REGISTRATION FORM FOR ADULTS **please complete in block letters**

Surname	First name
Street, no.	Postcode, town
Phone (home)	Phone (mobile)
Date of birth	E-mail
Marital status	Occupation
Family doctor	Emergency contact Name & phone
Legal representative / guardian	Have we been recommended to you? If yes, by whom?

Please answer every question by ticking the corresponding box. Your information will be treated in strict confidence and is subject to medical confidentiality.

Do you receive contributions towards dental treatment from the Office for Social Benefits (supplementary benefits)?	YES	NO
Do you receive contributions towards dental treatment from social welfare?	YES	NO
Do you receive contributions towards dental treatment from another authority? If yes, from which authority?	YES	NO

Dear patient

Your state of health can influence your dental treatment. We therefore kindly ask you to complete this questionnaire in full so that we can take your general state of health into account when planning and carrying out your dental treatment.

Are you currently receiving or have you recently received medical treatment? If yes, for which illnesses?	YES	NO
Are you currently taking any medication? If yes, which:	YES	NO
Do you have or have you ever had...		
high blood pressure?	YES	NO
low blood pressure?	YES	NO
a heart attack?	YES	NO
a stroke?	YES	NO
a congenital heart defect?	YES	NO
artificial heart valves?	YES	NO
an inflammation of the inner lining of the heart (endocarditis)?	YES	NO
a cardiac pacemaker?	YES	NO
blood-thinning medication?	YES	NO
asthma and/or hay fever? Please underline whichever applies	YES	NO
skin rashes?	YES	NO

Please turn over!

Do you have or have you ever had...		
a hypersensitivity reaction to medication or food? If yes, to what:	YES	NO
an allergy card (Allergiepass)? Please hand in a copy at reception	YES	NO
diabetes?	YES	NO
a kidney disease?	YES	NO
jaundice (hepatitis)?	YES	NO
tumour treatment with medication or radiotherapy?	YES	NO
epilepsy (seizures)?	YES	NO
medication for osteoporosis prevention (bisphosphonates)?	YES	NO
osteoporosis?	YES	NO

Do you smoke?	YES	NO
Are you HIV-positive?	YES	NO
Are you afraid of dental treatment?	YES	NO
Would you like to be reminded of your dental appointment?	by SMS	by e-mail
	I would like no reminder	

What do you expect from your treatment/care with us? Do you have any individual concerns?

For female patients		
Are you pregnant?	YES	NO
Are you planning a pregnancy?	YES	NO

I consent to data and findings from my medical records, including X-ray images or photographs, as well as copies or printouts thereof, being communicated or sent for medical purposes, at my request or on my instruction, to other medical professionals or to the health insurers, who are in turn bound by medical confidentiality.

I acknowledge that after surgical procedures or under local anaesthesia, active participation in road traffic may be associated with an increased risk of accidents for several hours. I agree that – if necessary – a local anaesthetic (local numbing) will be administered. With local anaesthesia (local numbing), irritation (numbness, tingling) of the lower jaw and the tongue can occur in very rare cases. This irritation usually disappears again.

The person treated undertakes to pay the invoice and to reimburse costs and expenses, plus value added tax. In the event that the invoice claim has to be enforced by way of debt collection and/or through the courts, the dentist is released from medical confidentiality in advance by the patient. This declaration also applies in the event of legal incapacity and beyond the death of the person treated.

With my signature I confirm that I consent to the processing of my data, to access to my data by the dentist, and to the transfer of my data to third parties in accordance with the patient information on the following page. I am aware of the possible risks of exchanging particularly sensitive personal data (possible access by unauthorised third parties via insecure communication channels) as well as of my rights, and I give my consent to mutual contact between my doctor and me as a patient through the contact information provided above. Patient information is passed on by the dental practice exclusively via secured communication channels. I agree that administrative matters, such as appointment changes, may be handled by unencrypted e-mail communication (@hin address to recipient addresses such as @bluewin.ch, @gmail.com etc.).

Furthermore, I acknowledge that if I am unable to attend, I must cancel my appointment no later than 48 hours before the agreed time. In the event of an unexcused failure to attend, the reserved time will be charged.

Bottmingen, _____ Signature: _____

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Patient information on the handling of personal data

Below we inform you about the purposes for which Zahnarztpraxis am Weiherschloss AG collects, stores or forwards your personal data. In addition, we inform you about the rights you can exercise within the scope of data protection.

Responsibilities

The entity responsible for the processing of your personal data, and in particular your health data, is Zahnarztpraxis am Weiherschloss AG. If you have any questions about data protection or if you wish to exercise your rights within the scope of data protection, please contact the practice staff or Dr. med. dent. Christian Dettwiler directly. Zahnarztpraxis am Weiherschloss AG and its employees are subject to professional secrecy. Patient confidentiality is fully maintained.

Collection and purpose of data processing

The processing (collection, storage, use and retention) of your data takes place on the basis of the treatment contract and statutory requirements in order to fulfil the purpose of the treatment and the obligations associated with it. On the one hand, data are collected by the treating practitioner in the course of your treatment. On the other hand, we also collect data from other physicians and healthcare professionals by whom you have been or are being treated, provided you have given your consent to this. Only data related to your dental treatment are processed in your medical records. The medical records comprise the personal details provided on the patient form, such as personal particulars, contact details and insurance information, as well as, among other things, the informed-consent discussion conducted as part of the treatment and the health data collected, such as medical histories, diagnoses, treatment proposals and findings.

Retention period

Your medical records are retained for 20 years after your last treatment. Thereafter, they will either be retained further with your express consent or securely deleted or destroyed.

Disclosure of data

We only transmit your personal data, and in particular your medical data, to external third parties if this is permitted or required by law, or if you have consented to the disclosure of the data within the scope of your treatment.

- Transmission to your health insurer or to the accident or disability insurance takes place for the purpose of billing the services provided to you. The type of data transmitted is governed by the statutory requirements.
- Disclosure to cantonal and national authorities (e.g. cantonal medical service, health departments, etc.) takes place on the basis of statutory reporting obligations.
- Depending on your treatment, transmission to a dental laboratory may be necessary for the manufacture of the corresponding dental appliance or dentures.

In individual cases, depending on your treatment and your corresponding consent, data are transmitted to other authorised recipients (e.g. other dental specialists, family doctors, state institutions such as SVA BL).

Revocation of your consent

If you have given your express consent to a data processing operation, you may revoke a consent already given at any time, in whole or in part. The revocation or a request to change a consent must be made in writing. As soon as we have received your written revocation and the processing cannot be based on any legal basis other than consent, the processing will be discontinued. The lawfulness of the data processing carried out up to the time of revocation remains unaffected by the revocation.

Information, access and release

You have the right at any time to receive information about your personal data. You may inspect your documents or request a copy of them. The release of a copy may be subject to a fee. Any costs, which depend on the effort required to produce the copy, will be communicated to you in advance.

Right to data portability

You have the right to have data that we process in an automated or digital manner handed over to you or to a third party in a common, machine-readable format. This applies in particular to the transfer of medical data to a healthcare professional of your choice. If you request the direct transfer of the data to another controller, this will only take place insofar as it is technically feasible.

Correction of your data

If you discover or believe that your data are incorrect or incomplete, you have the option of requesting a correction. If neither the accuracy nor the inaccuracy of your data can be established, you have the option of having a note of dispute added to your records.